Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2916AGC	A. BUILDING _____ B. WING _____	C 01/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE ASSISTED LIVING AT HENDERSON	1050 E LAKE MEAD DR HENDERSON, NV 89015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an complaint investigation initiated on 1/12/11 and concluded on 1/26/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 34 Residential Facility for Group beds for elderly Category I residents, and 18 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The following deficiencies were identified: Complaint #NV00027231 was substantiated. See Tag Y592.	Y 000		
Y 592 SS=D	449.268(1)(c) Resident Rights NAC 449.268 1. The administrator of a residential facility shall ensure that: (c) The residents are treated with respect and dignity. This Regulation is not met as evidenced by: Complaint #NV00027231	Y 592		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 592	Continued From page 1 Based on record review and interviews conducted between 1/12/11 and 1/26/11, the administrator failed to ensure that 1 Resident was treated with dignity and respect by a member of the staff (Employee #1). Findings include: Resident #1 was an alert and oriented resident living in the memory care unit of this facility. According to an interview with Resident #1, Employee #1 was rough with her approximately three times while changing incontinence products. On the first occasion Resident #1 asked Employee #1 not to be so rough. Resident #1 stated on the second occasion, which occured "a few months" prior to November, Resident #1 brought the issue to the attention of Employee #4. Employee #4 contacted Employee #5, who was the night shift manager, regarding the situation. According to Employee #4, Employee #5 brought the issue to Employee #6, however she is unsure if he took any action against Employee #1. Resident #1 stated on the third occasion, 11/24/10, Employee #1 was again rough when she changed her incontinent product. Resident #1 brought the issue to the attention of Employee #4 and #5. Employee #4 took Resident directly to Employee #7. Employee #7 and Employee #2 contacted Employee #1 immediately, and put her on suspension pending an investigation. The facility conducted an internal investigation. During the course of the investigation Employee #4 and #5 wrote statements confirming two instances when Employee #1 was rough with Resident #1. Employee #4 wrote a statement that documented she had never received a complaint from Resident #1, but she overheard	Y 592		

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Y 592	Continued From page 2 Employee #1 speaking aggressively to different residents, including Resident #1. As a result of the internal investigation Employee #1 was terminated. Employee #6 left the facility prior to the investigation. Employee #2 denied knowledge of the first incident, and was unable to provide documentation the facility took action related to the aggressive speaking and actions toward Resident #1. The facility failed to take appropriate action after members of management staff were aware of agressive language and behavior towards Resident #1. Severity: 2 Scope: 1	Y 592		